

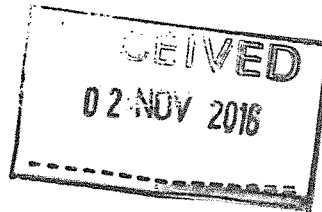
Our ref: [REDACTED]

1 November 2016

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Dear Miss Hamilton-Deeley

The Late Diana Ritchie, date of birth: 15 February 1933

Thank you for your report of 18 August 2016, and for drawing your concerns to my attention. I was very sorry to learn of the sad death of Mrs Ritchie. As you know, we are always willing to review our practices, in order to identify improvements which can be made in the light of experience.

I appreciate that with hindsight, it is likely that Mrs Ritchie's deterioration during the night of 5/6th March 2016 arose from the onset of broncho-pneumonia, although I am also aware that her clinical signs when she was examined at 03.45 were not such as to raise any suspicion of a chest infection. I acknowledge and deeply regret (as I know do the staff who were directly involved in her care) that there is just a possibility that with earlier escalation for assessment by critical care team members, the sequence of events for Mrs Ritchie might perhaps have been different. I am aware that she was seen and thoroughly assessed by her consultant on the morning ward round on 6 March, who did not feel that such escalation was indicated at that time, let alone earlier that day.

I recognise, as does the Trust's interim Chief Nurse, that accurate completion and scoring of observations on the National Early Warning charts, and appropriate escalation, is very important. In the light of these events, considerable action has been taken on the ward concerned (in conjunction with their matron) to ensure that the individuals directly caring for Mrs Ritchie, as well as the rest of the ward team, are fully familiar with what is expected of them. They have reflected carefully on this, as well as attending specific additional training since these sad events to improve their knowledge and skills. The ward action plan is being presented to the monthly audit meeting for women's services, as well as feedback being taken to the safety and quality meeting for wider learning.

With our partner

Teaching on completion of the National Early Warning System (NEWS) and escalation of concerning scores is included on the nurse induction course which every new member of nursing staff is obliged to attend. In addition, the Trust's Outreach team run teaching sessions on escalation of concerns arising from observations as part of the development programme for nurses, as well as running a monthly specialist training course for nurses which includes teaching on NEWS.

In order to extend this learning more widely, I used the Spotlight on Safety, in my weekly message to all staff, to focus on NEWS, saying - among other things - "it is vital that NEWS scores are calculated correctly and acted on appropriately if we are to provide safe care for our patients" and providing a direct link to the Trust's Patient Observation Policy.

The Trust's Patient Safety team sends a "Patients 1st" bulletin each month to all staff. This uses a fictionalized story to draw attention to things that may go wrong and sets out good practice. Since the death of Mrs Ritchie, such a bulletin has been circulated, which focused on the recognition and appropriate escalation of care for a deteriorating patient.

The Trust has also established a specific working group entitled "the Deteriorating Patient Steering Group" to coordinate work across the Trust to improve recognition of, and response to, any patient whose condition is deteriorating.

The Trust is considering carefully the series of actions which are essential before any electronic NEWS system can be introduced. The Trust provides clinical services in a wide range of buildings - some extremely old - across several sites. As an essential preliminary step, WIFI cover is being extended to cover the whole Trust. It is anticipated that this will be in place in 2017, enabling the Trust to make further progress in automating observations. The Trust Senior Management Team has given support in principle to the introduction of an electronic NEWS system, and the detailed business case required for such an investment is actively being taken forward.

Thank you once again for raising your concerns with me. Finally, please pass on my condolences on their sad loss to the family and friends of Mrs Ritchie.

Yours sincerely




Interim Chief Executive